STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255119	A. BUILDING _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 10/16/23 to 10/19/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F 561, F584, F656, F677, F684, F761, F812 and F880. The census at the time of survey was 104 and the facility was licensed for 152 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		11/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2023

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F 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and facility policy review the facility failed to ensure a resident's preferences was honored for one (1) of 20 sampled residents. Resident #70 Findings include: A record review of the facility policy titled, "Resident Rights & Quality of Life with a revision date of March 13, 2020, revealed that it is the policy that all residents and patients have the right to a dignified existence, self-determination, and communication with access to people and services inside and outside the center. An interview on 10/16/23 at 11:00 AM with Resident #70 revealed he didn't have coffee on his tray one morning a couple of weeks ago and he asked about it, he revealed one of the Certified Nursing Assistants (CNAs) stated, "Well they didn't put it on your breakfast tray, and I'll have to walk all the way back to the kitchen to get it." He revealed I didn't get any coffee that morning. An interview on 10/18/23 at 11:40 AM with Resident #70 revealed he did not get coffee again this morning for breakfast. He revealed, I told them that I wanted a cup of coffee, but I never got it. Resident #70 stated, "That's what I miss about being at home, getting coffee whenever I want it, at least for breakfast."	F 561	1. Resident #70 was informed on 10/18/2023 that his coffee would be served daily. Upon assessment by the Administrator on 10/18/2023 it was learned the resident has received his coffee routinely with this being an isolated occasion. No negative outcome was revealed during the assessment. The Nurse assure that Resident #70 received his coffee on 10/18/23 after the resident brought it to the attention of the surveyor. Dietary Manager was instructed by the Administrator on 10/18/23 to send coffee out in carafe with cups prior to serving trays so that CNA's could pass coffee prior to meals. 2. All residents who have the wish to have coffee have the potential to be affected by this deficient practice. 3. On 10/20/23 the Assistant Director of Nursing provided an in-service for staff on resident rights, including notice of meeting preferences related to coffee. Dietary staff were in-serviced by Dietary Manager on 10/20/23 that coffee is to served prior to trays being served. Dietary Manager was instructed by Administrator on 10/18/23 to send coffee out in carafe with cups prior to serving trays so that CNA's could pass coffee prior to meals. 4. The Administrator of Director of Nursing will conduct weekly audits of a minimum of 5 resident's who prefer to	

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F 561	Continued From page 2 An interview on 10/18/23 at 12:01 PM with the Administrator (ADM) confirmed Resident #70 should not have to go without his coffee that is his choice, and he should have had it, and she would take care of this issue right now. An interview on 10/18/23 at 12:10 PM CNA #5 revealed she is assigned to the resident, and he is a big coffee drinker. She revealed the food comes out to the hallways and we pass out the trays and then we go back to the dining room to the coffee bar and get them coffee. She revealed this morning she passed breakfast trays and then fed two residents and then helped pass out coffee. She revealed I thought the resident got coffee but I'm not totally sure. An interview on 10/18/23 at 12:36 PM with CNA #6 revealed I passed the breakfast tray to Resident #70 this morning and before I left the room, he said he wanted some coffee. She revealed his assigned aide was out in the hall and I let her know that he wanted coffee. She stated I think she got it for him but I'm not totally sure. Record review of Resident #70's Admission Record revealed the resident was admitted to the facility on 11/17/2022 with diagnoses that include Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Heart failure, and Chronic Obstructive Pulmonary Disease. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 08/10/23, revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident is cognitively intact.	F 561	drink coffee beginning on October 23, 2023 for three months. The Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months and as deemed necessary beginning with the November Quality Assurance and Performance Improvement Committee meeting on November 17,2023.	

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F 584	Continued From page 3	F 584		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		11/18/23

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F 584	Continued From page 4 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to ensure a clean environment as evidenced by multiple areas of a circular black substance on two ceiling air vents for two (2) of four (4) survey days. Findings include: Review of the facility policy titled "5-Step Daily Room Cleaning" undated, revealed, "PURPOSE: To teach Environmental Services employees the proper cleaning method to sanitize a patient room or any area in a healthcare facility ...2. Horizontal Surfaces- disinfected ... Use your high duster to dust hard to reach areas, such as the tops of closets, high lights, and ceilings areas as needed..." An observation on 10/16/23 at 12:42 PM, of the Dementia Care Unit, revealed two (2) square ceiling air vents with multiple areas of a circular black substance. The air vents had a total of 10 to 17 areas in total and ranged in different sizes of one-half (1/2) inch to two (2) inches. An observation and interview with Licensed Practical Nurse (LPN) #2 on 10/17/23 at 1:08 PM, revealed the air vents on the ceiling were an environmental concern related to moisture. She described the color of the substance adhering to the air vents as "dark black." She confirmed that the substance could be a health concern and could cause breathing issues.	F 584	1. The two ceiling vents on the Memory Care Unit were cleaned by maintenance on October 17, 2023. 2. All residents in the memory care unit have the potential to be affected by this deficient practice. 3. The Housekeeping Account Manager in-serviced housekeeping staff on 5 step daily room cleaning and 7 step daily washroom cleaning beginning on November 2, 2023 and completed the training on 11/3/2023. Cleaning of ceiling vents will be monitored weekly completed by the Housekeeping Account Manager and turned in weekly to the Administrator beginning on November 1, 2023. 4. Ceiling Vent audits Will be completed weekly starting 10/23/2023 and reported to Administrator, District Manager, Director of Operations every week for three months to ensure that ceiling vents are cleaned. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee for a minimum of three months by the Housekeeping Account Manager for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Meeting on November 17,2023.	

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F 584	Continued From page 5 An observation and interview on 10/17/23 at 1:11 PM, with Certified Nurse Aide (CNA) #2 revealed the black substance on the air vents, "Looks like mold." She revealed this could cause breathing problems for the staff and residents. An observation and interview on 10/17/23 at 1:15 PM, with Housekeeping Staff #1 confirmed the black substance on the ceiling air vents. She revealed the memory care unit has a housekeeper assigned daily to look for these issues. She revealed that the substance could cause breathing issues. An interview on 10/17/23 at 1:18 PM, with the Regional Environmental/Housekeeping Director #2 revealed the black substance on the ceiling air vents was from moisture. He revealed that housekeeping or maintenance was responsible for cleaning the vents. An observation and interview with the Administrator (ADM) on 10/17/23 at 1:20 PM, revealed the black substance on the air vents was "dust" and they've had this issue before.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		11/18/23

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F 656	Continued From page 6 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy	F 656	1. On 10/19/2023 Director of Nursing assessed resident #50 to determine	

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F 656	Continued From page 7 review the facility failed to develop a comprehensive care plan for a resident on hospice services (Resident #50) and failed to implement an Activity of Daily Living (ADL) care plan for shaving and oral hygiene for Resident #21, for two (2) of 20 residents reviewed. Findings include: Record review of the facility policy titled "Comprehensive Care Plans" undated, revealed, "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Resident #50 An interview on 10/19/23 at 9:27 AM, the Licensed Social Worker (LSW) revealed she is responsible for developing the hospice care plans. She confirmed that the hospice care plan was not developed for Resident #50 until yesterday. She revealed the Administrator came to her office and told her that the resident did not have an order in the computer for hospice, and unless there is an order in the system for hospice it will not generate a care plan to be developed. She confirmed the resident should have had an order for hospice and a hospice care plan when he was admitted to the facility. She revealed the care plan is to be individualized to each resident so that we know specifically how to take care of that resident and that the facility care plan should correlate with the hospice care plan. She stated	F 656	whether resident suffered a negative effect of the deficient practice. No negative impact was observed. On 10/18/2023 Social Services Director updated Resident #50's hospice care plan and Assistant Director of Nursing entered an order for hospice in to Point Click Care electronic medical record. On 10/17/23 Memory Care Unit Director assessed resident #21 to determine whether resident suffered a negative effect of the deficient practice. No negative impact was observed. On 10/17/23, the Director of Nurses updated Resident # 21's care plan to include ADL care needs. Beginning on 10/17/23 the Assistant Director of Nursing in-serviced CNA's related to ADL care. Nurses responsible for assuring these resident were shaved and oral care given where educated by the Memory Care Director beginning on 10/17/23. 2. All residents who require hospice service have the potential to be affected by this deficient practice. All patents who require ADL assistance have the potential to be affected by this deficient practice. 3. Director of Nursing, Assistant Director of Nursing, will review all residents in house to ensure ADL care plans are updated and in place by 11/3/23. Social Services Director will review all residents in house to ensure hospice care plans are updated and in place by 11/3/23. Assistant Director of Nursing will conduct an in-service with Social Services and interdisciplinary team regarding care plan updating policy by 11/3/23. On 10/17/23, the Assistant Director of nursing will	

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F 656	Continued From page 8 that the resident was admitted to the facility with hospice services on 6/21/23. A record review of Resident #50's Hospice care plan revealed it was developed with a date initiated of 10/18/2023. An interview on 10/19/23 at 10:30 AM the Director of Nurses (DON) confirmed Resident #50 did not have an order for hospice services entered into the computer system when he was admitted to the facility or a hospice care plan until it was brought to her attention yesterday. She revealed it was an oversight and it should have been done. She revealed the purpose of the care plan is developed so the facility staff and the hospice can coordinate specific care for the resident. A record review of the facility "Admission Record" revealed the resident was admitted to the facility on 6/21/2023 with diagnoses that included Chronic Diastolic (Congestive) heart failure, Acute and chronic respiratory failure with hypoxia, and Chronic obstructive pulmonary disease. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/27/23, and Section C revealed the Resident had a Brief Interview Mental Status (BIMS) of 13 indicating Resident # 50 was cognitively intact. Resident #21 Record review of Resident # 21's care plan, date initiated 10/10/2019, revealed, "Focus: I have a physical functioning deficit related to: Mobility impairment, Self care impairment ...Interventions	F 656	in-service staff on the Memory Care Unit regarding need to assure ADL care is provided to all residents. 4. The Social Services Director will monitor hospice care plans weekly times 4 weeks, bi-monthly times 1 month, monthly times 1 and then quarterly beginning on 10/20/2023. The results of these audits will be reviewed by the Quality Assurance and Performance Improvement Committee. The Assistant Director of Nursing will monitor ADL care plans weekly times 4 weeks, bi-monthly times 1 month, monthly time 1 and then quarterly beginning on 10/20/2023. The results of these audits will be reviewed by the Quality Assurance Performance Improvement committee. Findings of audits will be addressed in Quality Assessment and Performance Improvement Committee for a minimum of three months by the Director of Nursing or Assistant Director of Nursing or Social Services Director for review and interventions as necessary beginning with November Quality Assurance Performance Improvement meeting on November 17,2023.	

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F 656	Continued From page 9	F 656		

... I usually require limited times 1 (one) with toileting and personal hygiene .... Oral care assistance as needed ..."

An observation on 10/16/23 at 11:01 AM of Resident # 21 revealed the resident was noted with a buildup of a thick white substance on her lower teeth. Observed gray facial hair to the entire chin area measuring approximately one-fourth (1/4) inch in length and a thin layer of gray hair over the top lip measuring three-eights (3/8) inch.

During an observation and interview, with Licensed Practical Nurse (LPN) # 2, on 10/17/23 at 1:06 PM, she confirmed that Resident # 21 had a buildup of a white substance on her lower teeth. She revealed that the aides should be brushing her teeth three (3) times a day and should remove facial hair as part of the bathing routine or whenever needed.

An interview with the Director of Nursing (DON) on 10/18/23 at 12:08 PM confirmed that staff did not follow the care plan for Resident #21 related to grooming and oral hygiene and stated, "If it's care planned, it should be done."

An interview with the Minimum Data Set (MDS) Nurse on 10/19/23 at 8:48 AM revealed the purpose of the care plan was to have a person-centered guide for the nurses and aides to follow to care for the resident. She confirmed that Resident #21's care plan was not followed related to grooming and oral care.

Record review of the "Admission Record" for Resident # 21 revealed an admission date of 10/07/19 and medical diagnoses that included Unspecified Dementia, Hypothyroidism, Type 2

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F 656	Continued From page 10 Diabetes Mellitus with Hyperglycemia and Mild Intellectual Disabilities. Record review of the MDS with an Assessment Reference Date (ARD) of 9/11/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) score of 10, which indicated Resident # 21 is moderately cognitively impaired. Also revealed under section G, the resident required one (1) person physical assist with personal hygiene.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and facility policy review, the facility failed to provide activities of daily living (ADLs) for a resident dependent on staff for shaving and oral hygiene for one (1) of 20 residents sampled. Resident #21. Findings include: Record review of the facility policy titled "Activities of Daily Living (ADLs)" undated, revealed, "Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing,	F 677	1. Resident #21 was immediately assessed by Director of Nursing on 10/17/23. Resident #21 was shaved and mouthcare was provided by the Memory Care Unit Director on 10/17/23. On 10/17/23 1:1 education was provided to Certified Nursing Assistant's who failed to follow the care plan regarding facial hair and oral care by the Memory Care Unit Director concerning Activities of Daily Living care. On 10/17/23 Director of Nursing updated Resident #21's care plan to include need for shaving and oral hygiene. Nurses responsible for assuring theses residents were shaved and oral care given were educated by the Memory Care Director beginning on 10/25/23 concerning Activities of Daily Living care.	11/18/23

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 677	Continued From page 11 grooming, and oral care...Policy Explanation and Compliance Guidelines...2. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene ..." During an observation on the Dementia Care Unit on 10/16/23 at 11:01 AM, Resident # 21 was sitting in a chair and noted a buildup of a thick white substance on her lower teeth. Observed gray facial hair to her entire chin area measuring approximately one-fourth (1/4) inch in length and a thin layer of gray hair over the top lip measuring three-eight (3/8) inch. An observation and interview on 10/17/23 at 1:00 PM, with Certified Nurse Aide (CNA) #3 revealed she was assigned to Resident # 21 today. She confirmed that the resident's teeth needed brushing, and she was the person responsible for providing oral hygiene. She revealed that oral hygiene had not been done today, and it should be done after meals. She stated that the resident should have gotten the facial hair shaved on her bath day, which was yesterday, and confirmed that the aides were responsible for shaving facial hair and this care was included as part of bathing. An observation and interview with Licensed Practical Nurse (LPN) # 2 on 10/17/23 at 1:06 PM, confirmed that Resident # 21 had a white substance on her lower teeth. She stated, "It looks like gingivitis." She revealed that the aides should be brushing her teeth three times a day after meals. Not only that, but she confirmed that poor oral hygiene could cause infection, decay or could cause the resident to lose teeth. She confirmed that the resident should have facial hair	F 677	2. All residents requiring Activities of Daily Living assistance on the Memory Care Unit have the potential to be affected by this deficient practice. 3. On 10/25/23, the Memory Care Director provided assessments of all residents in the Memory Care Unit to determine whether there was anyone else who had not been shaved or given oral care. No additional residents were found. Beginning on 10/20/23, Activities of Daily living rounds will be completed weekly by the Director of Nursing or designee so that all residents will be rounded on during the month to verify Activity of Daily Living needs are being met. Beginning on 10/20/23, Director of Nursing, Assistant Director of Nursing will review all new admissions withing 24 hours of admit to verify that all team members are aware of Activity of Daily Living needs for each admission. Education will be provided to Certified Nurses Assistant's and Nursing beginning on 10/25/23 by the Assistant Director of Nursing or designee regarding assisting residents with Activities of Daily Living. 4. Audits will be completed by Director of Nursing or Assistant Director of Nursing on 5 residents in the Memory Care Unit weekly for 3 months to ensure that the Activities of Daily Living care plans are being followed beginning on 10/20/2023. Findings of audits will be addressed in the Quality Assurance Performance Improvement Committee meeting for a minimum of three months for review and interventions as necessary beginning with the November Quality Assurance	

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F 677	Continued From page 12 shaved as part of bathing routine or whenever needed. An observation and interview on 10/17/23 at 1:25 PM, with the Administrator (ADM) confirmed that Resident # 21 had white buildup on her lower teeth, which could lead to an infection. She revealed the resident should have oral hygiene three times daily and as needed. An interview with the Director of Nursing (DON) on 10/18/23 at 12:08 PM, revealed that female residents should have facial hair removed. She confirmed that shaving should be done on bath days or whenever needed as part of the grooming routine and care provided, and that Resident # 21 should have oral hygiene done after meals. She confirmed that the lack of oral hygiene could lead to loss of teeth, decay, infection, and pain. Record review of the "Admission Record" for Resident # 21 revealed an admission date of 10/07/19 and medical diagnoses that included Unspecified Dementia, Hypothyroidism, Type 2 Diabetes Mellitus with Hyperglycemia and Mild Intellectual Disabilities. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/11/23 revealed, under Section C, a Brief Interview for Mental Status (BIMS) score of 10, which indicated Resident # 21 is moderately cognitively impaired. Also revealed under Section G, the resident required one (1) person physical assist with personal hygiene.	F 677	Performance Improvement meeting on November 17,2023.	
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		11/18/23

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F 684	Continued From page 13 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review the facility failed to coordinate the hospice care for one (1) of four (4) residents receiving hospice services. Resident #50 Findings include: Record review of the facility policy/Health Care Services Agreement, dated Sept 30, 2016, revealed, "Exhibit A ... In order for this agreement to be mutually beneficial for both Hospice and Facility, the parties agree to develop mutually acceptable procedures for the following: A... Obtaining and recording physician orders ...E. Developing and updating plan of care ..." Record review of the facility Physician Orders for Resident #50 revealed an order to be admitted to hospice for diagnosis of congestive heart failure with a revision date of 10/18/2023. Record review of hospice (Proper name) Facility Notification of Hospice Admission/Change revealed Resident #50 was admitted to hospice services effective 6/14/2023. An interview on 10/18/23 at 3:25 PM, with	F 684	1. On 10/19/23 the Director of Nursing and the Assistant Director of Nursing assessed resident #50 to determine if resident has suffered a negative outcome from failing to coordinate hospice care. No negative effects were observed On 10/18/23, Social Services Director updated Resident #50's care plan related to hospice. Assistant Director of Nursing assured Resident #50's hospice order was placed into Point Click Care electronic medical record on 10/18/23. 2. All patients who require hospice services have the potential to be affected by this deficient practice. 3. Social Services Director or Social Services Assistant to review all residents on hospice services to ensure hospice care plans and hospice orders are updated and in place by 11/3/23. On 10/20/23 the Assistant Director of Nurses will conduct an in-service with Social Services and the interdisciplinary team related to care plan updating policy and the need to assure hospice orders are entered. 4. The Social Services Director will audit hospice care plans weekly times 4 weeks,	

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F 684	Continued From page 14 Licensed Practical Nurse (LPN) #1 revealed Resident #50 has been on hospice services for a long time. She revealed when he was admitted to the facility, he was already on hospice services. She confirmed his facility physician's order for hospice was dated 10/18/23 and his hospice physician order revealed he had been on hospice services since 6/14/23. An interview on 10/19/23 at 10:30 AM, with the Director of Nurses (DON) revealed Resident #50 was admitted on 6/21/23 to the facility for hospice respite care and the respite care ended on 6/30/23. She revealed he then transitioned to Long-term care at the facility and continued with hospice services. She confirmed that he did not have an order for hospice services put in when he was admitted to the facility until it was brought to her attention yesterday. She revealed it was an oversight and it should have been done. A record review of the facility "Admission Record" revealed the resident was admitted to the facility on 6/21/2023 with diagnoses that included Chronic Diastolic (Congestive) Heart Failure, Acute and Chronic Respiratory Failure with Hypoxia, and Chronic Obstructive Pulmonary Disease. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/23, Section O revealed the resident was under hospice care while he was a resident. A record review of the MDS with ARD of 09/27/23, Section C revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 13 indicating the Resident was cognitively intact.	F 684	bi-monthly times 1 month, monthly times 1 month and then quarterly to assure corrective action is effective beginning on 10/20/2023. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee for a minimum of three months by the Social Servies Director beginning with November Quality Assurance Performance Improvement Meeting on November 17,2023.	

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DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 761	Continued From page 15	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review, the facility failed to ensure a medication cart was locked while unattended for one (1) of four (4) survey days. Findings include: Record review of the facility policy titled "Medication Storage" with a revision date of 04/22	F 761	1. The Director of Nursing and Assistant Director of Nursing conducted rounds on 10/18/23 to assure that no resident was effected by the nurse failing to lock her medication storage cabinet. No negative impact was noted. 1:1 education was provided by the Assistant Director of Nursing to LPN #3 on medication storage and locking the medication cart on	11/18/23

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F 761	Continued From page 16 revealed, "...Procedure: ... It is the responsibility of the facility to keep the medication cart locked and secure at all times when not in use (during times other than medication pass and in between residents during medication pass) ...." During an observation of C Hall on 10/18/23 at 8:12 AM, the Survey Agency observed Licensed Practical Nurse (LPN) #3 walk away from the medication cart and enter room C11 without locking the medication cart. After several minutes, she exited room C11, walked over to the medication cart, opened the top drawer to obtain a lancet, shut the drawer and re-entered room C11 without locking the medication cart. An observation and interview on 10/18/23 at 8:23 AM, with LPN #3 confirmed that she had left the medication cart unlocked and unattended while entering a resident's room to give medication. She revealed that someone could come by and open the drawers on the medication cart and remove the medicine. An interview with the Director of Nursing (DON) on 10/18/23 at 8:28 AM, revealed the nurses know the medication carts should always be locked when unattended for safety. She confirmed that medication on the cart could be at risk for misappropriation when the medication cart is left unlocked.	F 761	10/18/23. In-service was provided to other nurses on locking the medication cart and medication storage on 10/20/23 by the Assistant Director of Nursing. 2. All residents have the potential to be affected by this deficient practice. 3. Education will be provided to Nurses beginning on 10/20/23 by the Assistant Director of Nursing regarding medicaiton storage and locking the medication cart. 4. Beginning on 10/20/23 while alternating medication carts and on different shifts a total of 20 checks per week will be conducted by the Director of Nursing, Assistant Director of Nursing or Unit Manager for a period of 3 months. To assure continued compliance with corrective action findings of audits with be reported by the Director of nusing addressed in Quality Assurance and Performance Improvement Committee for a minimum of three months for review and interventions as necessary beginning with November Quality Assurance Performance improvement Meeting on November 17,2023.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		11/18/23

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F 812	Continued From page 17 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to ensure that opened food items stored in the refrigerator were dated and labeled for two (2) of four (4) kitchen tours. Findings include: Record review of the facility policy revised 9/2017 and titled, "Food: Preparation" documented under "Procedures" the following, "...17. All TCS (Time/Temperature Controlled for Safety) foods that are to be held for more than 24 hours at a temperature of 41 degrees F (Fahrenheit) or less, will be labeled and dated with a 'prepared date' (Day 1) and a 'use by date' (Day 7). On 10/16/23 at 10:10 AM, a brief tour of the kitchen revealed an opened 32-ounce bottle of lemon juice which was approximately three-fourths full with no labeled date on the bottle. There was also approximately 2 cups of	F 812	1. On October 16, 2023, the Dietary Manger dated and labeled, lemon juice, peanut butter and jelly, and bologna. Pudding was disposed of in the trash On October 17, 2023 a bag of turkey was labeled and dated. The Dietary Manager educated Dietary Staff #2 on October 17, 2023 regarding the need to date and label all foods before placing them back in the cooler or freezer after opening the package. On October 17, 2023, the dietary staff looked at all foods in the kitchen, coolers and freezers to determine if any other food might be opened without a date or label. No additional food was noted. 2. All residents have the potential to be affected by this deficient practice. 3. Dietary Manager and or Cook will monitor cooler and freezer daily for three months to assure all opened foods are dated and labeled beginning on	

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F 812	Continued From page 18 brownish purple substance observed in a clear covered bowl which the Dietary Manager (DM) identified as peanut butter and jelly and there was no label or date on the container. There was also a gallon zip lock bag with light colored meat inside undated and unlabeled. This meat was identified by the DM as bologna which had just been opened during the preparation of breakfast that morning on 10/16/23. There was also observed approximately a gallon of a thick yellow substance in a covered bowl with no label and no date noted. The DM revealed that this yellow substance was pudding and she confirmed that everything should be labeled and dated when opened and prior to storage in the refrigerator. On 10/17/23 at 1:20 PM, a follow up tour of the kitchen revealed an unlabeled and undated zip lock bag about one-half full of white meat inside which was identified by the DM as turkey. The DM revealed that the meat should have been dated and labeled as soon as it was opened. On 10/17/23 at 1:30 PM, an observation and interview with Dietary #1 revealed that they (dietary staff) were responsible for dating and labeling everything as soon as it was opened. On 10/17/23 at 1:35 PM, an interview with the Healthcare Services District Manager, confirmed unlabeled and undated white meat in a gallon zip lock bag. On 10/17/23 at 1:40 PM, an interview with the Healthcare Services District Manager, revealed that all employees should be labeling and dating foods/items as they go. She revealed that as the staff opened and put things up, they should be labeled and dated right then. She also revealed	F 812	10/20/2023. The dietary manager completed education regarding labeling and dating open foods with dietary staff on October 19.2023. 4. Audits will be conducted by the Dietician/Dietary Manager weekly for three months beginning on October 20,2023. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee for a minimum of three months by the Dietician/Dietary manager for review and interventions as necessary beginning with November Quality Assurance Performance Improvement Meeting on November 17, 2023.	

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F 812	Continued From page 19 that not labeling and dating opened food items could cause many different problems including cross contamination, a risk of sickness, and a risk of residents with allergies receiving the wrong thing if not labeled properly. On 10/17/23 at 1:50 PM, an interview with Dietary Staff #2 revealed that she had opened the turkey up before lunch and failed to date and label it. She revealed that she tried to always put a date and label on everything she opened, but failed to this morning because she was in a hurry.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		11/18/23

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F 880	Continued From page 20 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 21 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to prevent the likelihood of the spread of infection as evidenced by a nebulizer and tubing not properly stored, hand hygiene not performed with incontinent care, and an isolation cart being transported in and out of a transmission-based precautions room for two (2) of 20 sampled residents reviewed. Resident #39 and Resident #83 Findings include: A review of the facility policy titled "Nebulizer Therapy", undated, revealed, "Policy: It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions ...Care of the Equipment: ... 7. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag. 8. Change nebulizer tubing every seventy-two hours or per facility policy. 9. Periodically disinfect unit per manufacturer's recommendations ..." Record review of the facility policy titled "Transmission-Based (Isolation) Precautions" undated, revealed, " ...Policy Explanation and Compliance Guidelines: 1. Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission ... 8. Initiation of Transmission-based Precautions ("Isolation	F 880	1. 1:1 education provided by the Assistant Director of Nursing to CNA #2 on 10/18/23 who failed to adhere to transmission based precautions guidelines concerning contact precautions, handwashing with return demonstration, peri-care checkoff, and isolation cart position. The Director of Nursing assessed resident #83 on 10/18/23 and identified there was no negative outcome for resident #83. The Director of Nursing assessed resident #39 on 10/18/2023 with no negative outcomes related to nebulizer storage. In-service by Assistant Director of Nursing to staff with return demonstration check off handwashing beginning on October 23, 2023. In-service by Assistant Director of Nursing to Certified Nurses Assistants with return demonstration of peri-care beginning on 10/23/23. In-services by Assistant Director of Nursing beginning on 10/20/23 to staff on transmission based precautions. In-service by Assistant Director of Nursing beginning on 10/20/23 to nurses on nebulizer storage. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. On 10/20/23, Director of Nursing conducted assessments of all residents currently on transmission based precaution to determine whether there was anyone else who staff failed to adhere transmission based precautions.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF AMORY	1215 EARL FRYE DRIVE AMORY, MS 38821

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F 880	Continued From page 22 Precautions")- ... f. The facility will have PPE (Personal Protective Equipment) readily available near the entrance of the resident's room and will don appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions. g. ... If sharing noncritical equipment between residents, the equipment will be cleaned and disinfected following manufacturer's instructions with an EPA-registered disinfectant after use ..." Record review of the facility Infection Control Guide Dated 2022 revealed, " ...Standard precautions include: 1. Hand hygiene before and after patient/resident contact-including after gloves are removed ..." Record review of the facility policy titled "Perineal Care" undated, revealed, "Policy: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown ..." Resident #39 An observation, on 10/16/23 at 10:45 AM, revealed Resident #39's nebulizer machine was lying in the corner of the room on the floor at the head of bed. The nebulizer mask was attached to the machine and lying flat on the floor next to the machine and was not covered or bagged. An interview on 10/16/23 at 2:30 PM, with Certified Nursing Assistant (CNA) #1 confirmed that Resident #39's nebulizer machine was sitting on the floor in the corner of resident's room and that the mask was laying on the floor beside it and was not covered. CNA #1 confirmed that it	F 880	No additional residents found. Isolation rounds will be completed weekly by the Director of Nursing, Assistant Director of Nursing, or Unit Managers so that all residents will be rounded on during the month to verify isolation needs are being met beginning on 10/20/2023. All residents with nebulizers were checked on 10/20/2023 to verify proper storage. The Director of Nursing or Assistant Director of Nursing will conduct a review of all residents with new diagnosis requiring transmission based precautions within 24 hours to verify that all team members are aware of isolation needs for each new diagnosis. Education will be provided by Assistant Director of Nursing to Certified Nurses Assistants, Nurses and staff beginning on 10/20/23 regarding following Infection Control guidelines in reference to handwashing, peri-care, transmission based precautions, isolation carts, and nebulizer storage. 4. Audits will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Managers on 5 residents weekly for 3 months beginning on 10/20/23 to ensure that the transmission based precaution guidelines are being followed. Audits will be completed by Director of Nursing, Assistant Director of Nursing or Unit Managers on all nebulizer storage weekly for 3 months beginning on 10/20/2023. Findings of audits will be addressed in Quality Assurance Performance Improvement Committee for a minimum of 3 months by the Director of Nursing or the Assistant Director of Nursing for review and interventions as	

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	255119	A. BUILDING _____ B. WING _____	10/19/2023

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F 880	Continued From page 23 should not be sitting on the floor and that the mask should be in a bag. CNA #1 confirmed that with the mask lying on the floor it could become contaminated with germs. An interview on 10/16/23 at 2:35 PM, with the Assistant Director of Nursing (ADON) confirmed that Resident #39 had nebulizer treatments and that the nebulizer that is sitting on the floor in the corner of the room with the mask lying on the floor beside it belongs to Resident #39. The ADON confirmed that it is an infection control issue and that it could spread germs. She confirmed that the machine should be sitting on a table beside the bed and that the mask should be in a plastic bag when not in use. An interview, on 10/18/23 at 3:00 PM, with the Director of Nursing (DON) confirmed that no nebulizer should be on the floor and that the mask should be bagged when not in use. The DON confirmed it is an infection control issue. Record review of the Order Review Report for Resident #39 revealed an order effective 10/17/23 for Albuterol Sulfate Inhalation Nebulization Solution 0.083% 3 (three) ml (milliliters) inhale orally via (by) nebulizer every 6 hours for cough and congestion for 5 (five) days. A review of the Admission Record for Resident #39 revealed that he was admitted to the facility on 08/14/23 with diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia and Hypertensive Chronic Kidney Disease. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/12/23 revealed a Brief Interview for Mental Status	F 880	necessary beginning with November Quality Assurance Performance improvement Meeting on November 17,2023.	

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F 880	Continued From page 24	F 880		

(BIMS) score of 11 which indicated Resident #39 was mildly cognitively impaired.

Resident #83

An observation on 10/17/23 at 10:30 AM, of Resident # 83's door revealed a sign on the door that read, "Contact isolation." There were two (2) red biohazard barrels observed inside the resident's room.

Record review of Resident # 83's urine culture results dated 10/13/23 revealed findings, "Greater than 100,000 colonies per ML (milliliter) of Escherichia Coli confirmatory ESBL (Extended Spectrum Beta-Lactamase) POS (positive)"

An observation of incontinent care for Resident # 83 on 10/18/23 at 10:58 AM, with Certified Nursing Assistant (CNA) # 2 revealed she applied a gown outside the resident's room and then pushed a 3-compartment rolling isolation cart inside the room and left it beside the bathroom doorway. She applied gloves that she gathered from the isolation cart and did not perform hand hygiene. CNA # 2 provided incontinent care for Resident #83 and when done, she removed her gloves and reached inside the isolation cart to get a new pair of gloves. She applied the gloves and removed the resident's soiled pull up brief from around the resident's lower legs. She applied a clean pull up brief and completed the care after disposing of the linen and trash inside the biohazard containers in the room. She removed her gloves and pushed the isolation cart back into the hallway.

An interview with CNA #2 on 10/18/23 at 11:15 AM, confirmed that she did not perform hand

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F 880	Continued From page 25	F 880		

hygiene upon entering the room, after changing gloves and following the incontinent care. She revealed that not performing appropriate hand hygiene was an infection control issue. She stated that she "should have" washed her hands to prevent the spread of infection. CNA #2 also confirmed that she took the isolation cart into the room with her and that it should be left outside of the door and that she could see how that would spread infection by taking something into the room and bringing it back out.

An interview with the Infection Preventionist on 10/18/23 at 3:10 PM, confirmed that lack of hand hygiene while performing incontinent care could cause the spread of infection. She revealed the aides have check offs for incontinent care and were inserviced on the importance of handwashing. She revealed that the isolation cart should never be pushed inside the resident's room due to cross contamination and should remain on the unit.

An interview with the Director of Nursing (DON) on 10/18/23 at 4:06 PM, revealed that staff has been educated on handwashing, and they know that taking an isolation cart in and out of a resident's room was cross contamination and could increase the spread of infection.

A record review of the facility "In-Service Training Record" revealed an in-service was conducted on 10/12/23 for the topics of Hand Hygiene and Peri care and CNA #2 signed as attended.

Record review of the Admission Record for Resident # 83 revealed an admission date of 9/09/21 and medical diagnoses that included Unspecified Dementia, ESBL Resistance, Urinary

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F 880	Continued From page 26 Tract Infection, and Type 2 Diabetes Mellitus. Record review of the MDS with an ARD of 9/13/23 revealed under Section C, a BIMS score of 10, indicating Resident # 83 has moderate cognitive impairment. Section H indicated the resident is frequently incontinent of bladder and Section G revealed she requires one-person physical assist with toileting.	F 880		